

**Official Application For Licensure As
A Pharmacist By Examination**

Please check attached fee schedule for proper fee.
All paperwork must be complete before you are eligible for the Exam.

Please check which Exam(s) you are requesting. ☐ NAPLEX ☐ MPJE
☐ Score Transfer

EXAM GRADES	DO NOT WRITE IN THIS SPACE	Paste One Photo in this space Present second photo when appearing for exam. Photo must be a recent likeness. Signature must appear on photo.
NAPLEX _____ MPJE _____ Received: _____ Fee Paid: \$ _____ Receipt No.: _____	EXAMINATION Granted/Denied License #: _____ Date: _____	

PLEASE TYPE OR PRINT APPLICATION

Applicant's Full Name:

First

Middle

Last

Address:

Street and Number

City

State

Zip

Date:

Phone No.: ()

I, _____, being of good moral character and having had the required practical pharmaceutical experience and having graduated from an accredited college of pharmacy approved by the Arizona State Board of Pharmacy, do now submit the following information and supporting affidavits relative to my birth, age, character, education and practical experience to establish my eligibility for examination and licensure as a pharmacist under laws and regulations applicable thereto in this State.

Place of Birth

Month Day Year

Present Age

Sex

Social Security #

Have you ever been known by any other name?
If yes; _____

PREVIOUS LICENSURE AS A PHARMACIST

Applicant must list all places, dates and results of all Board examinations taken for licensure as a Pharmacist in any state.

Previous Examination and Score	Name of State	Exam Date(s)	Score Transfer	Full Exam	Passed		Certificate Number	Date Issued	Is license in good standing?	
					Yes	No			Yes	No

Previous licensure as licensed pharmacist by reciprocity (License transfer)	Name of State	Date Acquired	Certificate Number	In good standing?	
				Yes	No

All practice as Pharmacist after licensure to date of filing this application (If not actually engaged in Pharmacy, enter in chronological order what occupation you pursued during that period of time.)	Name of Pharmacy (State if employee or owner)	Address of Pharmacy (Give street, city, state)	Period of Service	
			From	To

ATTACH SEPARATE SHEET IF NEEDED

PHARMACY COLLEGE TRAINING (DO NOT INCLUDE PRE-PHARMACY TRAINING)

Name and Location of College Attended

Period of Attendance

1 st Year _____	From _____	To _____
2 nd Year _____	From _____	To _____
3 rd Year _____	From _____	To _____
4 th Year _____	From _____	To _____

I was granted a diploma of graduation from the _____ College of Pharmacy on the _____ day of _____, _____, the _____ degree being conferred.

(IMPORTANT: Transcript of College Record and Certification of Graduation must be submitted to Board Office by College of Pharmacy.)

CHARACTER VOUCHERS

THE BOARD OF PHARMACY REQUIRES EACH APPLICANT FOR EXAMINATION TO PRESENT 2 CHARACTER VOUCHERS FROM PERSONS OVER 21 YEARS OF AGE WHO HAVE KNOWN THE APPLICANT AT LEAST ONE YEAR. (NOTE: Information provided is for Board of Pharmacy use only and will not be released under any circumstance.)

1. To the Arizona Board of Pharmacy:

This is to certify that _____ to the best of my knowledge is not addicted to the use of habit forming or narcotic drugs; is not a chronic or persistent inebriate; has not been convicted of any violation of federal or state laws pertaining to drugs or devices; is of good moral character and will, in my opinion, be a credit to the profession of pharmacy.

I have read the foregoing certification and have been personally acquainted with _____
Name of Applicant
 for _____ years.

I have the following additional comments to make with reference to the applicant's moral character:

Signed: _____

Date: _____ Address: _____

2. To the Arizona Board of Pharmacy:

This is to certify that _____ to the best of my knowledge is not addicted to the use of habit forming or narcotic drugs; is not a chronic or persistent inebriate; has not been convicted of any violation of federal or state laws pertaining to drugs or devices; is of good moral character and will, in my opinion, be a credit to the profession of pharmacy.

I have read the foregoing certification and have been personally acquainted with _____
Name of Applicant
 for _____ years.

I have the following additional comments to make with reference to the applicant's moral character:

Signed: _____

Date: _____ Address: _____

Title II of the Americans with Disabilities Act (ADA) prohibits the Board of Pharmacy from Discriminating on the basis of disability in the provision of its programs, services and activities. Individuals with disabilities who require this material in an alternative format may contact the agency's ADA Coordinator at 623-463-2727, extension 127.

INTERN LICENSURE

Name of State	Certificate Number	Date Issued	Is license in good standing now?	
			Yes	No

INFORMATION IN THIS SECTION SHALL BE VERIFIABLE THROUGH STATE BOARDS OR PRECEPTOR.

RECORDS OF CHARGES, CONVICTIONS AND FINES IMPOSED ON APPLICANT

“No charges involving moral turpitude or violations of pharmacy, liquor or controlled substance laws ever made or pending.” _____ (Initial)

APPLICANT MUST INITIAL ON LINE PROVIDED IF STATEMENT IS TRUE; EXPLAIN IN SPACE PROVIDED BELOW IF ANY CHARGES.
(use separate sheet if more space required)

FOR BOARD USE ONLY

PROOF OF IDENTITY

I am a citizen of the United States _____. I am a Resident Alien _____.

To prove age and identity, I enclose certified copy of: (check proper box)

Birth Certificate ☐

Other Affidavits ☐

If name is different from birth certificate, ☐
please submit supporting evidence.

Name: _____

To substantiate education and practical experience claimed, I submit the necessary affidavits which become a part of this application.

I solemnly swear and affirm that I have personally filled in this form, and that the information is true and correct to the best of my knowledge and belief.

Applicant Sign Name Here in Full

State of: _____, County of: _____. Subscribed and sworn to before me this
_____ day of _____, _____.

Notary Public

My Commission Expires: _____